POST-DEPLOYMENT HEALTH REASSESSMENT

PDHRA

JANUARY 9, 2006

Post-Deployment Health Reassessment (PDHRA)
Executive Summary

The Post-Deployment Health Reassessment is a force health protection process designed to enhance the deployment-related continuum of care. Targeted at three to six months post return from a contingency operation, the PDHRA provides education, screening and a global health assessment to identify and facilitate access to care for deployment-related physical health, mental health and re-adjustment concerns.

Key Points:

- Health and adjustment concerns may not be noticed immediately after deployment. In subsequent months post-deployment, concerns may surface ranging along a continuum of severity. While effective health care and adjustment counseling services are available, service members may be unfamiliar with navigating the various systems of care. The PDHRA is designed to identify conditions that emerge and facilitate access to services for a broad range of post-deployment concerns.
- Similar to other medical readiness programs, the PDHRA is a commanders program; commanders are charged with ensuring that service members are provided this opportunity and are encouraged to fully participate in this program.
- Key elements of the PDHRA include outreach, education and training, screening and assessment, evaluation and treatment, and follow-up. Screening is conducted to identify current concerns, while education is important for issues that emerge outside the screening timeframe. Leaders, service members, and clinicians are educated on the PDHRA process, commonly occurring signs and symptoms, available benefits and how to access those benefits. Effective education to gain leadership support, service member participation, and optimal clinical practice is critical to program success.
- Screening and assessment are accomplished using standardized questions for service member screening and standard assessment procedures administered by primary care providers. Quality assurance and program evaluation are planned to assess implementation effectiveness and program success.
- Treatment and follow-up are arranged on a continuum of care model. The continuum ranges from community based support and preclinical counseling to referral for treatment in primary care, specialty care or rehabilitative care when warranted. Behavioral health providers are being increased in primary care settings in the military healthcare system to increase timely access to low-stigma care. Follow-up procedures will reduce potential barriers to access.
- To ensure program success and smooth integration into existing processes, small scale implementation was initiated at high-deployment platforms beginning in June 2005. Lessons learned will maximize successful program deployment on a wider scale in January 2006. Full implementation will follow an iterative process, beginning with units scheduled for return deployments and based on Service identification of highest need.

Why do we need a new program?

The PDHRA is designed to enhance and extend the deployment-related continuum of care. Deployment health concerns are assessed immediately at the end of deployment through the Post Deployment Health Assessment (PDHA). The PDHA also includes education, a benefits briefing, a self-report questionnaire, and an interview with a healthcare provider. However, not all health concerns present at this single point in time; and members focused on going home may be reluctant to report concerns at this time. Readjustment issues will not emerge until the member re-enters their work and family environment. After members have time to reflect on their deployment and post-deployment experiences, they may be in a better position to identify concerns, questions, and issues they wish to discuss with a healthcare or other service provider.

Isn't the PDHRA only a self-administered questionnaire?

The PDHRA is a process that does include completion of a series of questions. These questions have been drawn from standard, established methods of screening. The questionnaire provides a structured way to collect information for the provider to use in their assessment and to provide all service members with the same opportunity to formulate questions and concerns in their mind before meeting with the provider. The concerns identified on the questionnaire are then discussed in a one-on-one visit with a trained healthcare provider. Even for members who have no questions or concerns, education about commonly experienced concerns and avenues to access care will arm the service member with tools they need to identify and seek care for issues that surface at any time, even if they are not present at the precise time the assessment is conducted.

Is the PDHRA available for everyone, regardless of their component or service?

The PDHRA is offered to active duty, guard, reserve and those who separate from military service after return from a contingency deployment. Every attempt is made to make the process convenient and easy to complete. A web form has been developed to allow for ease of completion; and a call center has been established to provide telehealth assessment services for those who live at a distance from a unit or healthcare setting.

Is it a mandatory program?

It is a mandatory process for all current active and reserve component members. How much or how little information they disclose about their concerns, of course, cannot be mandated. Obviously, members who are no longer a part of the military have the option to participate, but cannot be required to do so.

Post-Deployment Health Reassessment (PDHRA)

Background: Personnel returning from deployment have been shown to have an increased risk of physical and mental health issues. Currently, deployed personnel complete a pre-deployment health assessment prior to being deployed and a post-deployment health assessment leaving theater. Recent field research has indicated that health problems are frequently identified several months after returning from deployment. The current post-deployment health assessment process as been extended to include a post-deployment health reassessment 90 to 180 days post-deployment. This extension of the current post-deployment health assessment process is designed to identify health concerns that emerge over time following return from deployment. The PDHRA is both an assessment and education process. The process includes use of, but is not equivalent to, a clinical assessment tool with validated screening scales. A trained health care provider will review responses to the tool with the service member along with other health concerns associated with returning from deployment. Results from the PDHRA become a part of the individual's military health record and will be included in the Defense Medical Surveillance System.

1. What are the key elements of the PDHRA mission?

The PDHRA was designed to provide outreach, early intervention, and a reduction in barriers to care for service member with deployment-related health concerns that emerge subsequent to return from deployments. The PDHRA mission key elements include:

- Reach out and touch each individual. This is a positive outreach message that demonstrates that we understand that deployments can negatively affect health, that we respect the service members' efforts, and that we care about their quality of life enough to ask how they are doing. This is a significant outreach and educational initiative, not an effort to find pathology where it does not exist.

- Early identification. Chronic health conditions eventually come to the attention of the health care system, but often years later. Putting off a visit to the doctor is fairly common in the human experience. However, those delayed presentations often entail significant costs, increased personal distress, and decreased satisfaction with care. We learned that lesson following the 1991 Gulf War. Early, proactive identification of conditions before they become chronic facilitates definitive treatment and reduces probability of chronicity and associated cost in terms of health care dollars and individual distress. Early identification also facilitates access to a less intensive intervention milieu, such as to preclinical counseling or readjustment counseling or to primary care rather than to more intensive and lengthy subspecialty care.

- Education. There will never be an exactly ideal time at which to assess and intervene for every service member. Therefore, the PDHRA relies heavily on multiple levels of information and education delivered to multiple audiences in the PDHRA process.

First, information must be presented about the PDHRA process and the importance of full participation for service members, leaders, and clinicians as well as to family members when possible. Next, clinicians must be educated in how to assess, evaluate and treat deployment-related conditions; leaders must be educated in how to recognize conditions and ensure their personnel have access to the care they need; and service members must be educated in common conditions and concerns as well as the full spectrum of health care benefits available to them and which benefit is most appropriate for their concerns. In addition, the most effective information delivery comes through effective health risk communication on the part of clinicians. Research suggests that communication is more effective when it is targeted to the population and when it comes from a trusted source. For many people, the most trusted source of information is a healthcare provider. By providing effective health risk communication from a clinician, the educational message is more likely to be received and believed.

- Access to care. A number of barriers to care exist in the federal health care system. PDHRA attempts to increase access to care by removing barriers associated with myths, misunderstandings, complexity of healthcare and community support benefits, and increased knowledge of resources for pre-clinical and clinical care. Effective education and outreach begins the process, ensuring service members know the range and avenue for accessing care and receive assistance in finding easy access to timely appointments continues the process, and follow-up to ensure that care is received completes the access process.

2. What is the role of the DD Form 2900?

The DD Form 2900 is a tool to assist in standardizing collection of self-report information from the patient, to facilitate standardized assessment, and to facilitate standardized documentation of the assessment itself. The DD Form 2900 is not equivalent to the PDHRA process as a whole. The PDHRA is a process that includes use of the DD Form 2900 as a tool in that process. The process includes:

- Identification, Notification and Outreach. Individual service members are identified as requiring the PDHRA and notified of the requirement and method for completing the process. Service members and leaders receive outreach information about the nature of the PDHRA, why it is important and what it can do for them.
- Education and Training. Service members receive information and education about common deployment-related health concerns and the continuum of benefits available and appropriate for those concerns.
- Screening and Assessment. Service members complete the self-report portion of the DD Form 2900. Clinicians review positive responses and conduct a clinical assessment to determine the need for further, more definitive evaluation and/or treatment and the appropriate level of care for referral.

- Evaluation and Treatment. Service members are referred by the assessing clinician, with administrative input from benefits advisors or unit personnel specialists, to a level of care appropriate for definitive diagnosis and/or treatment or intervention.
- Follow-up and case management. Service members receive a follow-up contact to determine if they received an appointment with the referral source, if they kept the appointment, and other outcome information. Potential obstacles are removed to facilitate making and keeping timely referral appointments.
- Quality assurance and program evaluation. Services are responsible for ensuring that the PDHRA is implemented with fidelity. A centralized process and outcome evaluation and a cost-benefit analysis are being conducted during FY06.

3. How was the DD Form 2900 developed and how is it used?

The DD Form 2900 was developed through an intensive, iterative process by a cross-functional, inter-service, interagency team of subject matter experts, including subject matter experts from the VA, international experts, and joint DoD experts in preventive medicine, public health, primary care, mental health and behavioral sciences. It built on the use of existing standardized scales currently in use in primary care settings and in the DD Form 2796. It has been further studied in terms of utility and efficacy through scientists at the Walter Reed Army Institute of Research in Europe. It provides for identification of physical health symptoms that have been identified with deployment-related health concerns and conditions, potential exposure "worry" (often associated with subsequent development of chronic, multi-symptom illness), mental health conditions, and family and relationship conflict and concerns. Mental health scales were selected to identify conditions for which evidenced-based assessment and treatment is available. The questions were then submitted to the Joint Public Health and Preventive Medicine Working Group for approval.

The form includes scales recommended by DoD/VA clinical practice guidelines and scales that are currently being used by the VA for all incoming OIF/OEF patients. The form and the process were discussed with the DoD/VA Deployment Health Working Group, beginning first in February 2005, to provide information and receive input. The PDHRA was also discussed at DoD/VA Mental Health Conference in March 2005. At the conference, a number of presentations were made by VA and Vet Center staff indicating that similar processes had taken place as a result of state-level partnerships between the VA and National Guard units.

The form itself is used as a guide for clinicians to further interview service members to identify conditions and concerns that would warrant a closer look. It also allows for self-referral by service members who may wish to speak to a healthcare provider or counselor but do not wish to disclose the information at this time or simply wish to discuss questions rather than symptoms. A key component in use of the form is training clinicians. Implementation of the process through effective clinical procedures takes precedence over the static elements on the form. A tool is only as useful as the craftsman who uses it.

Therefore, clinical guidance, clinician training, and other clinical primers and tools were created and provided to clinicians in an electronic format.

The DoD requires that all service members who report any level of symptoms, questions or concerns on the DD Form 2900 will be interviewed by a independently practicing clinician, such as a physician, physicians assistance, or nurse practitioner. The Army and Marine Corps maintain that land combat troops experience a higher risk for development of health problems and may also have a culture that discourages care seeking. Therefore, they have increased the requirement for all members to be interviewed by a clinician regardless of their responses on the DD Form 2900. They believe that members may report issues to a clinician that they would be reluctant to write down on paper. The Navy supports the Marine Corps position and is similarly requiring all sailors to see a health care provider. The Air Force has experienced fewer reports of health concerns. They furthermore have established an annual Preventive Health Assessment or PHA for all airmen. Because of the increased frequency of health assessments already and the perceived decreased risk, they have adopted the DoD requirement. The PHA is currently being implemented across DoD, which would provide annual assessments for all active and reserve component personnel. Standardized scales are being used on the PHA similar to the ones used on the PDHA and PDHRA. Once this assessment process is fully implemented, the DoD will examine the efficacy of replacing the PDHRA with the PHA to eliminate redundant assessment processes. Until that time, the PDHRA serves an important role in education and early identification of health conditions and concerns.

Once completed, the DD Form 2900 contains standardized information to document the encounter and is filed in the service member's medical record. The electronic information is submitted to the Defense Medical Surveillance Database and in Service-specific medical readiness tracking systems for inclusion in the electronic medical record and for medical readiness tracking. Service member contact information is provided on the form so that follow-up can be conducted to ensure that members who received referrals were successful in getting the referral care completed. A supplemental form will be used to record follow-up actions and outcomes. Satisfaction questionnaires will also be included as a supplement to the DD Form 2900 to determine service member satisfaction with the form and the assessment, referral, and education process.

4. Who is eligible to participate in the PDHRA process?

Health concerns often emerge weeks or months after deployment, rather than immediately at the end of the deployed period. Naturally, those who deploy to a combat theater tend to experience more frequently occurring conditions. However, those who deploy away from family, away from familiar environments, and away from the availability of services through a fixed medical facility have also been found to be at increased risk for both physical and mental health concerns. The high OPTEMPO associated with the Global War on Terror has increased fatigue and stress on multiple systems while decreasing opportunity for effective self-care and restoration processes. Length of deployment and

number of times deployed tend to be associated with an increased frequency and severity of health problems. The Post Deployment Health Assessment, or PDHA, has been required of all members who deploy for 30 days or more to a location without a fixed medical facility. The PDHRA is intended for all those who were required to complete a PDHA. A new beneficiary population was not established; the existing medical readiness requirements were confirmed for this program. Commanders further have the option to require their members to participate based on their unit-based risk assessment. Therefore, all service members who deployed during the GWOT, beginning on September 11, 2001, are eligible to participate in this outreach, education, and care access program.

It is also important to recognize that September 11 changed the culture of this country regarding deployment on US soil. Prior to that date, it was inconceivable that there could be an attack within our borders and the concept of deployment within our own borders was equally unheard of. We are now in the process of changing our culture in terms of concept of deployment as well as in delivery of federal healthcare services. Consistency in action and the messages delivered are important to ensure that the change is effective. For example, in the DoD, we are attempting to promote early intervention and decrease stigma associated with care-seeking. In the DoD/VA Post-deployment Health Clinical Practice Guideline (PDH-CPG), we encourage service members without symptoms, but with questions about how deployments could possible affect their health, to seek answers in a visit with their primary care manager. In the VA, the two-year policy was designed to change the culture from one of requiring the veteran to demonstrate proof of service-connection and reliance on disability to provide care. Early entry into the system, promotion of a positive, therapeutic relationship before conditions become chronic, positive outreach to reserve component personnel are all goals of the new VA. The message that is desired is: It's not your grandfather's VA; the VA provides a full continuum of care for both female and male veterans across the spectrum of age. The implied and direct messages established in the PDHRA program can assist in moving those desired beliefs forward and in effecting the desired culture changes.

This program is mandatory for active and reserve component personnel. Everyone must have the opportunity to participate. Commanders are responsible for ensuring that all personnel receive the education and are exposed to the questionnaire and clinical assessment. The extent to which they actually report health concerns is voluntary. Not all questions on the DD Form 2900 will be answered by all participants.

5. Isn't the PDHRA really intended to identify only mental health conditions and concerns?

The PDHRA is intended and designed as a global health assessment, to look at physical health, mental and behavioral health, as well as family and social adjustment. We have learned over the course of time that deployment-related health concerns emerge weeks, months, or even years after the deployment.

Because of this knowledge, the DoD/VA Post-deployment Health Clinical Practice Guideline (PDH-CPG) was developed and implemented to identify these concerns as they are presented in primary care settings long after the deployment ended. Those conditions included multiple physical and mental health conditions. Unfortunately, it may take years for these conditions and concerns to be presented to a primary care setting, long after the time for effective early intervention has past and after the patient has developed a negative affect toward the healthcare system. At a late date, the tie to deployment may be difficult to discern, generating additional negative discourse between the patient and healthcare system and creating a need for the patient to prove disability before his/her condition qualifies for treatment. This "contest of wills" can actually perpetuate pathology rather than remediate disease.

In addition, health concerns are not always easily categorized based on symptoms. Some physical health problems present with traditional mental health symptoms and mental health problems present with physical health symptoms. Family and social adjustment and other psychosocial stressors create a negative impact on both physical and mental health. Only through global health assessment can early intervention into symptoms be effectively accomplished.

6. What health care and readjustment benefits are available for active duty, reserve component, and separated service members following completion of the PDHRA?

The PDHRA seeks to identify and provide early, easily accessible intervention for conditions or concerns that were caused by or aggravated by deployment. Those conditions call for care through federal healthcare benefits. It is right and just to care for our nation's veterans, regardless of the nature, severity, or timing of the distress they experience as a result of service to our country. Additional benefits have been developed and provided for this high-risk population. The services fall along a full continuum of care from preventive counseling to rehabilitative care.

- Prevention: Education and effective clinical risk communication can be very beneficial in reducing worry about the potential effects that deployment might have on the health of an individual or family. Health education and/or discussion of health risks and normal bodily functioning with a trusted healthcare provider can assist in allaying worries and concerns.

- Secondary Prevention: Family, interpersonal, or work conflict or adjustment problems along with pre-clinical levels of anger or grief can be effectively addressed with pre-clinical, readjustment counseling. For active and reserve members and their families, Military OneSource provides educational products on the web, counseling on a variety of topics by phone, and face-to-face counseling in the local community for 6 sessions per person per problem. If problems persist or present with clinical symptoms, a warm hand-off is made from the OneSource Counselor to the appropriate healthcare system.

For Guard and Reserve members and for those veterans who have separated from Service subsequent to deployment to a combat theater or in direct support of a combat operation or those who are eligible to receive an expeditionary or other combat-related medal or award, the Vet Centers provide readjustment counseling and support in addition to and similar to OneSource. The Vet Centers also provide more traditional mental health treatment, should that become necessary; or can refer to the VA Medical Center or Community Outpatient Clinic for additional treatment resources. All veterans who support contingency operations are eligible for care in the VA. However, those who do not fall under the two year combat support regulation must enroll and establish healthcare eligibility to determine the appropriate category of care based upon income levels and service-connected injuries.

Community-based services are also available, including referrals to chaplains, family pastors, or self-help and support groups. The family support, family service, or National Guard family readiness centers provide information and referral services for community based services. OneSource also provides referrals to local community-based services when appropriate and requested.

- Clinical Care: For active duty, care is available through the military health system or through TRICARE. Active duty members have individually identified primary care managers who manage care or consult specialty care when needed. There has been an increase in the behavioral health specialists who are located in primary care clinics to provide consultative or collaborative care and behavioral health treatment in the primary care setting. Those behavioral health providers are being increased through the PDHRA program. Specialty care is available in mental health clinics at military medical facilities. In addition, for those members who are geographically separated from a military medical facility, TRICARE provides for 8 mental health visits without the need for primary care referral or TRICARE authorization. Reserve and guard members are eligible for TRICARE for 6 months post-deployment, including mental health care benefits. Those who deploy in support of a combat operation also are eligible for treatment in a VA Medical Center, Outpatient Clinic, or Vet Center. Care based on line-of-duty determinations may be appropriate for those not entitled to VA care but who experience health conditions that arise as a result of active duty service.

- Rehabilitative Care: Rehabilitative care is available through the military health care system major medical centers as well as through the DoD Specialized Care Program for chronic illness or PTSD. VA offers specialized outpatient, inpatient, and residential rehabilitation programs through joint VA/DoD Polytrauma Centers, regional Spinal Cord Rehabilitation Centers, and rehabilitation for PTSD in Medical Centers and Vet Centers for eligible veterans.

- Tertiary Prevention: Severely injured service members and their families receive support and case management services at the individual medical facility and through

Service-specific case management programs as well as family support through the DoD Military Severely Injured Joint Operations Center. Nurse case managers have been assigned to all military major medical centers and OIF/OEF liaisons are located at all VA Medical Centers to assist in case management for complex cases.

7. Who is responsible for implementing this program in DoD?

The military departments were tasked with implementation for both the active and reserve component of their Service. The M&RA of each military department will develop an implementation plan and guidance for the field. In the field, it is a commander's responsibility to ensure that this and other medical readiness requirements are completed. While DoD can establish policy and core requirements, it is up to each Service to execute that policy based on their unique needs and configuration. DoD will continue to be engaged to interpret policy, to provide assistance requested by the Services that can best be accomplished centrally, and to monitor quality and consistency in implementation.

To provide the most effective implementation possible, the Services are beginning the process through small-scale implementation sites. These preliminary implementation processes are designed to identify glitches in the logistics and procedures so that full-scale implementation will not be hampered by fixable problems. The intent is to identify logistics, throughput, automation and training issues that can be corrected. The small scale projects have yielded lessons learned and issues that have been corrected in an iterative fashion. As problems present, they are corrected and further processing yields additional issues which are corrected. The program will continue to roll out on an iterative basis to further provide continuous process improvement.

To further facilitate methodical service provision for all service members who have deployed during the GWOT, a phased approach has been adopted. Those who are currently in the assessment window (who returned during the past 6 months) are being provided PDRHA services first. The next group will include those who have returned in the year preceding implementation of this program (entered the assessment window from June 2004-June 2005), with emphasis on high risk groups who experienced high casualty rates and/or who are scheduled for return to an operational deployment. Finally, those who returned prior to that period will be contacted and offered the opportunity to participate. For those who have separated from service, a centralized call center has been established to provide telehealth screening and assessment services.

In addition, a program evaluation has been designed and is underway. This full-scale, centralized program will evaluate the process, the outcomes, and the cost-benefit of the program. It will be conducted during the first year of implementation. It is being conducted through an external contract with John Snow Inc. and Harvard Medical School to ensure an unbiased, scientifically rigorous evaluation is accomplished. Results will inform DoD policy and procedure.

8. **How is the health information obtained through the PDHRA best shared between DoD and VA to ensure continuity of care?**

To provide continuity of care for clinical issues, information from the PDHRA and associated clinical procedures must be seamlessly shared between the two healthcare systems. The information management personnel of the two agencies are current working to develop an effective information sharing system. Immediate, short-term and longer-term, more permanent procedures are being developed to facilitate rapid access to clinically relevant information. Information sharing procedures still need to be sorted out by relevant legal experts in both systems and consistently presented and clarified to the field.

Appendix 1. TAMP

Transitional Assistance Management Program: A Transitional Health Benefit Program for Service Members and Their Families

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TAMP: TAMP is a 180-day extension of the TriCare health benefit for certain military members and their eligible family members that takes effect upon separation from active duty. Because TriCare Prime is a managed health plan with provider panels organized by specific geographic location, Service Members covered by TriCare Prime must re-enroll in that program in order for TAMP to provide benefits at the TriCare Prime level. Such re-enrollment must take place within 180 days of separation from active duty. If a member covered by TriCare Prime requires health services prior to re-enrolling they will still be covered by TAMP but at a lower level of reimbursement associated with a non-Prime benefit plan.

Eligiblilty: TAMP covers the following four categories of Service Members and their eligible family members:

1. Members *involuntarily separated from active duty;*
2. Reserve Component *members released from active duty* after having been activated, mobilized, or deployed in support of a contingency operation for a period of more than 30 days;
3. Members *separated from active duty* after being involuntarily retained in support of a contingency operation; and
4. Members *separated from active duty* following a voluntary agreement to stay on active duty for less than one year in support of a contingency mission.

Health Plans Not Affected: TAMP is not provided under either TriCare Prime Remote or TriCare Prime Remote for Active Duty Family Members because these plans require the Service Member to be on active duty and they expire when the Member is separated.

Summary of Benefits:

	TriCare Prime	TriCare Extra	TriCare Standard
Re-enrollment (for members enrolled during AD period)	Required with 180 days of separation No waiting period	Not Required	Not Required
Start Date	Immediately upon separation, but at a higher cost-share if not re-enrolled in Prime	Immediately upon separation	Immediately upon separation
New Prime Enrollees	Prime starts the 1st of the month following re-enrollment by the 20th day of the month.	Not applicable	Not Applicable
Annual Deductible	None	E-5 and above: 150/individual $300/family E-4 and below: $50/individual $100/family	E-5 and above: $150/individual $300/family E-4 and below: $50/individual $100/family
Annual Enrollment Fee	None	None	None
Civilian Outpatient Visit (Medical and Mental Health)	No cost. Eight unmanaged MH sessions	15% of negotiated fee. Eight unmanaged MH sessions	20% of allowed charges for covered service. Eight un-managed MH sessions
Civilian Inpatient Admission	No cost	Greater of $25 or $14.35 per day	Greater of $25 or $14.35 per day
Civilian Inpatient Behavioral Health	No cost	Greater of $20 per day or $25 per admission	Greater of $20 per day or $25 per admission
Civilian Inpatient Skilled Nursing Facility Care	$0/diem/ admission No separate cost share for separately billed professional charges	$11 per day per admission ($25 minimum)	$11 per day per admission ($25 minimum)

TriCare RESERVE SELECT (TRS) ENROLLMENT %

Effective Date. Beginning April 26, 2005, certain members of the National Guard and Reserve have been able to purchase premium-based health coverage under a TriCare health plan named *TriCare Reserve Select* for themselves and their family members. This program is available to Reserve Component (RC) members who separated from qualifying active duty service on or after April 27, 2005.

Eligibility. RC members may be eligible to purchase TRS if they meet these requirements:

1. They were called or ordered to active duty under Title 10 in support of a contingency operation for more than 30 consecutive days on or after Sept 11, 2001.
2. They served continuously on AD for 90 days or more under such call or order.
3. They entered into a Serve Agreement (DD Form 2895) to serve in the Select Reserves.

Coverage Period. The period of coverage under TriCare Reserve Select varies depending on the number of days served on active duty.

Days Served on Active Duty	Maximum Period of TRS Coverage
90 – 179 days	1 Year
180 –269 days	2 years
270 – 359 days	3 years
360 – 449 days	4 years

Participation Rate. The following is an estimate of the percentage of qualifying RC members who have enrolled in this plan.

TriCare RESERVE SELECT (TRS) Participation Rate

Reserve Select Eligibles (TAMP Expirations) 78,997 est.*

Reserve Select Option Exercised 17,927 22.7% (+/-- 1.2%)

As of: April 27, 2005 through January 6, 2006

***** Source: CTS Deployment File actual separations April 27 through November 2005 plus estimates for December, 2005 and January 1- 6, 2006 based on current trend lines and past experience.

Decision Period. RC must indicate their interest in enrolling prior to leaving active duty and execute a Service Agreement within four months thereafter. Additional requirements apply. For details go to www.tricare.osd.mil/factsheets/ or call 703-681-1775.